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ABSTRACT

This paper offers a rationale for offering sexuality education for youth with mental handicaps, and outlines several myths about human sexuality and the mentally handicapped. Sexual rights of the mentally handicapped are listed. Items that should be included in sexual counseling are noted. The paper also discusses critical content areas in sexuality education, effective teaching techniques, modification of instructional objectives and classroom activities to meet special students' needs, and selection and modification of materials. Attachments include methods for individualizing instructional objectives, a sexual bill of rights for people with disabilities, a privacy values clarification strategy, and a checklist for parents to indicate appropriateness of various behaviors. (JDD)

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Special Needs Adolescents and Sexuality Education: A Health Challenge for the Nineties

ASHA 1993 Conference Presentation

Pittsburgh, Pennsylvania

Principles, philosophy, and assumptions undergirding the teaching of sexuality education to special needs adolescents

The principles and philosophy for sexuality education for special needs adolescents is clear: "Sexuality is an inherent characteristic of humankind existing at birth and extending throughout the life span." (Scarborough & Ortinau, 1973) "Withing broad limits, the development of the mentally and physically handicapped follows the same schedule as normal persons, except that these kids require more time to advance from one stage to another." (Morgenstern, 1973) Even so, the emotional and physical

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development, the sexual drives and impulses, the concerns and anxieties, the guilt, hangups, and inhibitions, and the need for sexual expression of the handicapped are very similar to the nonhandicapped.

Human sexual behavior is more than just sexual intercourse: it also involves interpersonal relationships in a general sense, appreciation of sex in the development of the person, the ability to make informed decisions in social-sexual matters, accurate information about sexuality, and social concepts such as dating, marriage, parenthood, and responsibility for one's behavior. Adequate sexual functioning requires the comprehension of and integration into behavior of abstract ideas, such as the consequence of one's acts, subtle cues in human relations, and the control of strong impulses--areas in which mentally handicapped folks may be the weakest.

A society which still has not come to terms with its own sexuality has even greater difficulty coming to terms with the concept of sexuality for its handicapped youth. In spite of this hesitancy to deal with sexuality education for its youth, sexuality education is essential for the mentally handicapped for the following reasons:

1. There is broad consensus that the mentally handicapped are ignorant in sexual matters, and that this ignorance contributes to exploitability and community rejection. According to Sol Gordon and others the mentally handicapped are easily and frequently sexually exploited, more vulnerable, more gullible, more easily coerced, bribed, or blackmailed with regard to sex.

2. The mentally handicapped are more likely than nonhandicapped to be arrested for any unacceptable social-sexual behavior in the community because they are more noticeable.

3. They are generally weak in judgment. Developmentally, they have not reached a level of achieving an internalized conscience, so they must be taught in terms of good versus bad and taught to do whatever they are instructed.

4. Mentally handicapped people may be inclined to express affection through physical contact. This inclination may be the result of a craving for love, warmth and closeness coupled with a lack of effective verbal communication.

5. As they must be taught all other adaptive behaviors, they must be taught about sexual behavior. The mentally handicapped adolescent is more unlikely than the nonhandicapped peer to acquire accurate information from incidental learning from peers. S/he is also more more often deprived of peer group

associations and relationships which would help validate their ideas about sex. Consequently the mentally handicapped may believe the fantasies from television or the myths propagated in institutions.

6. They generally have limited access to educational information as a result of their poor reading skills, their language difficulties and their conceptualization difficulties.

7. Generally parents of these special needs adolescents deny that their children are sexual beings or are overprotective; both of these attitudes result in sparse or no parental sexuality education.

8. Finally, none of the research cited any serious problems with acting out behavior following sexuality education courses. (McCombs,1980)

Myth About Human Sexuality and the Mentally Handicapped

1. It is not possible for a Down's Syndrome female to conceive.

Myth. The reproductive system is the least likely to be involved. It is true that males may have some difficulty physiologically with a low sperm count which is related to infertility.

2. An effective method of contraception for a mentally handicapped female is the DepoProvera injection.

Fact. This is an oilbased injected contraceptor which inhibits ovulation for three months. Its side effects can be troublesome; some women stop having periods, and 2/3rds don't ovulate 6-18 months after their periods begin again. Mildly handicapped females have approximately the same rate of conception as do nonmentally handicapped women. Moderately handicapped women may experience more incidences of abusive sexual behavior and need a more controlled environment for sexual activity.

3. A profoundly mentally; handicapped individual does not possess sexual drive.

Myth. Define for me if you will what is sexual feeling. Very difficult because of its subjective quality. It can be defined as tactile interactions with pleasurable reactions.

4. The incidence of sexually transmitted diseases among mentally handicapped persons is three times greater than that of the normal population.

Myth. Mildly mentally handicapped have a rate equal to that of nonhandicapped.

5. The mentally handicapped male, who for physical and mental reasons will never have sexual intercourse, will build up serious sexual frustrations.

Myth. Sexual satisfaction is not synonymous with sexual intercourse. There are a variety of sexual behaviors which give sexual pleasure.

6. Mentally handicapped children are more likely than normal children to be "sexually used" by others.

Fact. The abuse is more likely to occur in the home rather than outside the home. It usually does not occur to the profoundly handicapped, many are institutionalized; it occurs to 90% of the moderately and 75% of the mildly handicapped.

7. All professional and supportive staff of an institution for the mentally handicapped need sexuality education.

Fact.

8. The mentally handicapped vary in their interest in sex just as the so-called normal do.

Fact.

9. Sterilization is illegal in some states.

Myth. 25 years ago it was readily available. It is legal in all 50 states and requires informed consent for those testing 65-85 IQ and considered borderline. Six states permit sterilization of institutionalized MH. 16-18 states OK the sterilization of MH women and include legal safeguards to ensure their rights. In 4 states parents may NOT sign for their children. The remainder of

the states use common law based on legal precedent. The Association for Voluntary Sterilization has developed legislation to allow access to sterilization for the MH.

10. Mentally handicapped girls tend to be more promiscuous than girls of higher intelligence.

Myth. Judgment is impaired. Try to please. More vulnerable. Confuse physical contact with affection.

11. For some mentally handicapped persons, masturbation may be the only satisfactory means of sexual expression.

Fact.

12. Sexuality education for the borderline and educable mentally handicapped person is much the same as for those of higher intelligence.

Fact.

13. It is usually possible to predict whether a mentally handicapped person will have difficulty making a social sexual adjustment in the community by his or her behavior in the institution.

Myth. Behavior that is learned can be unlearned.

14. It is against the law for married mentally handicapped residents to live together in institutions.

Myth.

15. Children of the mentally handicapped often function at a retarded level because of lack of intellectual stimulation in the home.

Fact. If both parents have less than an IQ of 65 there is a 40% chance that children will have an IQ of 61%. If one parent has an IQ of less than 65 there is an 15% chance that children will be mentally handicapped. 1% is neither is MH and 3% is the population at large. Genetically MH parents do not AUTOMATICALLY produce MH children.

16. There is no established correlation between the success of marriages of mentally handicapped persons and their choice of having children within the marriage.

Unknown. A study was done in England in the 1960s but there was not enough data generated to make valid conclusions.

17. Of the charges lodged against mentally handicapped persons, almost one third are sexually related. The offenses committed are usually of a fairly harmless nature, such as public masturbation or indecent exposure.

Fact. Judgment lacking. Need to be taught those behaviors which are appropriate in public and those done privately.

18. Homosexuality is more common among deaf persons.

Myth.

19. Men with spinal cord injuries can never achieve erections.

Myth.

20. Sexuality education has been shown to lead to earlier sexual experimentation due to stimulation and curiosity aroused by this information.

Myth. Research indicates that the opposite is true; that sexuality education helps postpone sexual activity and engenders more responsible behavior like using contraceptives when sexual activity is initiated.

Sexual Rights of the Mentally Handicapped

The right to:

1. Receive training in social-sexual behavior that will open more doors for social contact with people in the community.
2. All the knowledge about sexuality they can comprehend.
3. Enjoy love and be loved, including sexual fulfillment
4. The opportunity to express sexual limpulses in the same forms that are socially acceptable for others.
5. Marry.
6. Have a voice in whether to have children.
7. For supportive services which involve those rights as they are needed and feasible.

Source: Gary F. Kelly, Sexuality Today The Human Perspective, 1988, p. 192.

Sexual Counseling of the Mentally Handicapped Adolescent

1. Masturbation is a normal sexual expression no matter how frequent or at what age it occurs.
2. All sexual behavior involving the genitals should occur only in private.
3. Any time a sexually mature girl and boy have intercourse, they risk pregnancy.
4. Unless a couple clearly want a baby, they need to understand and practice effective birth control.
5. Society decrees that no one should have intercourse until about age 18. At that age women and men are ready to make such a decision for themselves.
6. Adults must never use children sexually.
7. With appropriate safeguards, sexual expression may be encouraged.
8. Private sexual activity is acceptable between consenting adults.

Source: Sol Gordon, "A response to Warren Johnson," in F. de la Cruz and G. LaVeck, Human Sexuality and the Mentally Retarded, 1973, pp. 68-69.

Sexual Bill of Rights for People who are Disabled

The right to:

1. Sexual expression
2. Privacy
3. Be informed
4. Access needed services (contraceptive counseling, genetic counseling, sexual counseling) and medical care
5. Choose one's marital status
6. Have or not have children
7. Make decisions affecting one's life
8. Develop to one's fullest potential

Eight positive statements about the sexuality of people with disabilities **Source:** Francoeur, Becoming a Sexual Person,1991, p.511.

1. Genital function alone does not make a functional relationship.
2. Urinary incontinence does not mean genital incontinence.
3. Absence of sensation does not mean absence of feelings.
4. Inability to move does not mean inablility to please or be pleased.
5. The presence of deformities does not mean the absence of desire.
6. Inability to perform does not mean inability to enjoy.
7. Loss of one's genitals or the ability to have intercourse does not mean loss of sexuality.

8. Sexual dysfunction is not synonymous with personal inadequacy.

Critical Content Areas for Adolescents with Special Needs

The critical content areas in sexuality education for special needs adolescents are the same as those for their nonhandicapped peers:

1. Body parts,
2. Functioning of the reproductive system, and
3. Appropriate social/sexual behavior.

Although essentially complex, there are four principles for effective teaching of the mentally handicapped learner: (1) task analysis - a skill to be learned is identified with subsequent subskills which comprise the steps the teacher will follow to reach a specific objective; (2) Use of multisensory concrete materials - anatomically correct dolls, sanitary napkins and tampons, condoms, birth control methods, audiovisual materials including books, magazines, pictures, animals, slides, films etc.; (3) repetition of information; and (4) practice of functional skills - role playing and dramatized experiences of real-life situations. Teaching skills through functional tasks, instructional games and fun activities with repeated performance can be used for mastery. There are several sexuality programs available for mentally handicapped

adolescents and many provide a complete curriculum as well as materials to assist the teacher and learners.

Blind adolescents lack the visual stimuli which can help satisfy sexual curiosity and make them more prone to developing misconceptions about sexuality. Knowledge of sexuality stems from the input of other senses. A child is able to feel his or her own body but may not have a frame of reference for a body of the opposite sex. Exploring with the hand, something usually encouraged in blind kids, can be inappropriate and socially unacceptable in the context of learning about sexuality. Adolescence creates additional problems for the blind adolescent as the concept of self may be negative due to the blindness. There is the inability to look in the mirror and visually compare her or himself with peers; consequently, it is difficult to achieve a sense of normalcy and a sexual identity. (Smigielski and Steinmann, (1981)

Because of limited social interaction and limited mobility, blind adolescents may have fewer opportunities to experience social environments outside the home or school. Blind adolescents must also understand that although they cannot see, they can be seen and some behaviors must only be done privately.

A teaching plan for blind adolescents should incorporate (a) concrete teaching, (b) the use of other senses to compensate for the

lack of visual input, (c) reinforcement from peers and significant others, and (d) opportunities for social learning. The visually handicapped adolescent may not understand abstract concepts for which there is a visual reference (e.g. menstruation), teaching content must be concrete and frequently related to the student's personal experience. Without vision the blind student needs touch, smell, taste and hearing in order to learn. Creative strategies might include distinguishing males and females by smell. In addition to factual information the blind adolescent needs the psychosocial aspects of sexuality, the feelings and emotional elements. (Smigielski and Steinmann, (1981)

There are talking books, large print books and books in braille available which contain a variety of topics related to sexuality education. Audiotapes have been developed which discuss body changes during puberty and guide the student to explore her or his own body. There is an audiotactual program to describe intercourse and childbirth to visually handicapped children; it uses anatomically correct cloth dolls.

Techniques to Modify Curricular Objectives, Methods, and Materials

The student who is mainstreamed, that is mildly handicapped, may exhibit general cognitive dificits or specific disabilities.

Academic skills such as reading, writing, and arithmetic are probably deficient, as are general organizational and study skills. This student may also have difficulty with attentional deficits - may be highly distractible, for example, or even hyperactive. The health educator can frequently help this student with relatively minor modifications in the instructional program by making minor adaptations and developing alternate approaches and materials which will be helpful to others in the class as well. (Olasov, Bruno, and Simon, 1986)

Modifying Instructional Objectives

Modifications may and can be made for the mildly handicapped when setting instructional goals for that student. Because most students with learning problems tend to work more slowly than their nondisabled peers, it is essential the objectives are chosen with care. **It is important to determine which objectives are critical since time is usually insufficient to cover them all.** For example, material on contraception would be a higher priority than material on sex role stereotyping.

Once the objectives have been selected they can be adjusted to address individual educational needs in a variety of ways. (Thiagarajan,1980,**attachment 1, at the end of the paper**). A teacher could adjust the entry level of the objective so that it is not

quite as difficult for the student. An objective phrased so that it demands a recall response could, for instance, be altered so that it demands a recognition response (**see example 1).**
Similarly, as in **example 2,** an instructor can alter the step size required so that the student will be able to master material in smaller chunks: instead of having the student describe all the physiological changes occurring in puberty, for example, the student might be asked to list only the secondary sex characteristics of the male or female.

A third method for adjusting objectives might be to increase the number of prompts and aids which the student is allowed to use. **(example 3)** If an objective, calls for the student to describe the unique functions of the male and female reproductive system, an adjusted version might allow the use of a labeled diagram of the two systems to assist in an explanation. The teacher can also adjust the indicated behavior required in an objective as long as the intent of the objective stays the same. Instead of requiring a student to write a two page essay on the question, "Is going steady a good idea/", an objective may call for the student to give a 10 minute speech on the topic. **(example 4)** And, finally, standards contained in the objective can be adjusted to meed the needs of slower students. An objective requiring 95% mastery of the topic

could be adjusted to allow for 80% accuracy for the student, at least initially. **(example 5)**

Modifying Classroom Activities

There are several ways to enhance direct teacher activities. Firs, the teacher should insure the student is attending to instruction. Seat the student close to the instructor thus minimizing distractions. Use verbal cueing workds such as **this is important** also helps. Visual cues also may be used such as giving the student an outline of the lecture or steps of the demonstration. Overheads, words on the board, and models of the reproductive system are all examples of visual aides that focus the attention of the student. Tactile cues may help in attending. Have students point out items on a chart or model to provide feedback that they are comprehending the instruction. (Olasov, Bruno, and Simon, 1986)

During direct teacher instruction, the teacher should also use simple vocabulary to increase comprehension of concepts. New important vacabulary terms should be introduced prior to including those terms in a lecture. For some students, this may mean utilizing flash cards or a language master to teach the vocabulary. For others a glossary of terms on a handout may besufficient.

Independent student activities are designed to reinforce direct teacher instruction and give students additional practice with

concepts. Frequently students are expected to read materials like a text before class discussion. Many mildly handicapped students are able to comprehend and participate in class lectures, but have difficulty with reading materials. Several alternatives to the usual reading of the text may help the special student. The teacher could provide a summary of the text section written by herself or a student, which covers essential facts, but omits extraneous material. The teacher might also underline or highlight with a marker lines of passages and have the student only read those essential parts. Reading with a tutor or listening to others read the text aloud may be feasible alternatives in some classrooms. Another alternative to reading the text is to actually rewrite the material, simplifying the vocabulary, or to provide the student with a lower level textbook including the same content.

Yet another alternative is to tape record the text. For this to be effective, several suggestions are offered: 1) read only the critical content and eliminate the rest, 2) a marking system should be used to aid the student in coordinating the recording with the text so s/he may follow along easily, 3) passages read word for word might be marked with a solid line and those summarized or paraphrased marked differently like a dotted line. Tape recordings also offer the opportunity to teach study skills. For example,

students can be directed to look at the questions at the end of selection prior to reading. Explanations of charts and diagrams should be included on the tape. The teacher can also use the tape to relate new content to previously learned material. Students might listen to the tapes at home, in a resource room, or on headphones in the regular classroom. Evaluate the option of tapes carefully as it is time consuming and some students also have listening deficits.

Writing activities may also be modified for the special student. A completed lecture outline will assist the student who has difficulty with organization and writing; these outlines also help in report preparation. The student can complete the outline and then write sentences and paragraphs from the outline. The student whose writing is laborious can be assisted by decreasing the number of items on the page, do odd numbers only on a worksheet. The student will still be a part of the class, but will not be penalized for the time it takes to organize an answer and write legibly. (Olasov, Bruno, and Simon, 1986)

Simplifying directions and vocabulary will also inclrease the probability that a student will complete a worksheet independently. Key words in a text or on an assignment sheet can also be circled or highlighted to assist in comprehending directions. Use of a routine format, such as fill in the blanks, also helps the student work

without asking for teacher assistance. Items should be written as simply as possible. For example, the item: "The organ in the female body called the _____ is the organ in which the fetus develops" can be simplified to "_____ is the organ in the female where the fetus develops>." **(see example of the simplified drawling of the female reproductive system, attachment 2 at the end of the paper)**

Selecting and Modifying Materials

Very little effort needs to be expended to adapt, adjust, or modify the many materials available to supplement classroom sexuality education. With these minor adjustments the materials can be better used by the mainstreamed student and will better serve her/his needs. A suggestion which will enable the teacher to adjust is to simplify terms on printed materials, diagrams, written and verbal instructions and procedures.

Limiting choices on a student worksheet is yet another form of simplification. If a student has a values clarification exercise to complete, for example, s/he will be better able to deal with a limited number of choices in trying to clarify values. Rather than asking the student to choose from a five point scale of "strongly agree" to 'strongly disagree" with a neutral choice as a possibility, limit the choices to "yes" or "no" with a followup discussion to

elicit additional reasons and feelings.

As mentioned previously, use concrete materials whenever possible. For all students and especially for the mainstreamed student "hands on" materials and concrete examples are of tremendous assistance when attempting to learn concepts. These kinds of materials bring a realism to the topic which a two dimensional textbook drawing cannot. For example, there are several kinds of kits available using actual products to explain menstrual hygiene.

Adopt a multisensory approach. Coordinate audio tapes with diagrams. Give the student something to touch and feel. There are birth control methods which can be passed around the classroom. There are fetal development kits, for example, which allow the students to pick up models of fetuses which are contructed to feel and look like actual fetuses as they grow and develop during pregnancy. Also available are anatomically correct cloth dolls.

It is helpful for the teacher to supervise frequently and thus to give feedback to the student who is using materials. Both the teacher and the student benefit from this kind of ongoing and constant monitoring.

Selected Strategies

1. Privacy circles **(Attachment 3 at the end of the paper)**

2. Appropriate social behavior **(Attachment 4 at the end of the paper)**

OBJECTIVE: After reading a chapter on teenage pregnancy, the student will be able to write a list of at least eight social, economic and health consequences of teenage pregnancy. The student must complete the list within 10 minutes and is not allowed to look back at the story.

TYPE OF ADJUSTMENT	EXAMPLE OF ADJUSTING DOWNWARD
1. Adjusting the entry point	The student will be able to write a list of eight consequences of teenage pregnancy when given a list of twenty possiblities.
2. Adjusting the step size	After reading a section of a chapter on teenage pregnancy, the student will be able to list at least 2 economic consequences of teenage pregnancy.
3. Adjusting prompts and aids	The student may look back to the story, which she/he has been able to underline.
4. Adjusting the indicator behavior	The student will orally state at least 8 consequences of teenage pregnancy.
5. Adjusting the standards	The student will be given a half hour to complete the list and will be allowed to make one error.

Adapted from: Thiagarajan, S. Individualizing Instructional Objectives. Teaching Exceptional Children, Spring, 1980, p. 126-127.

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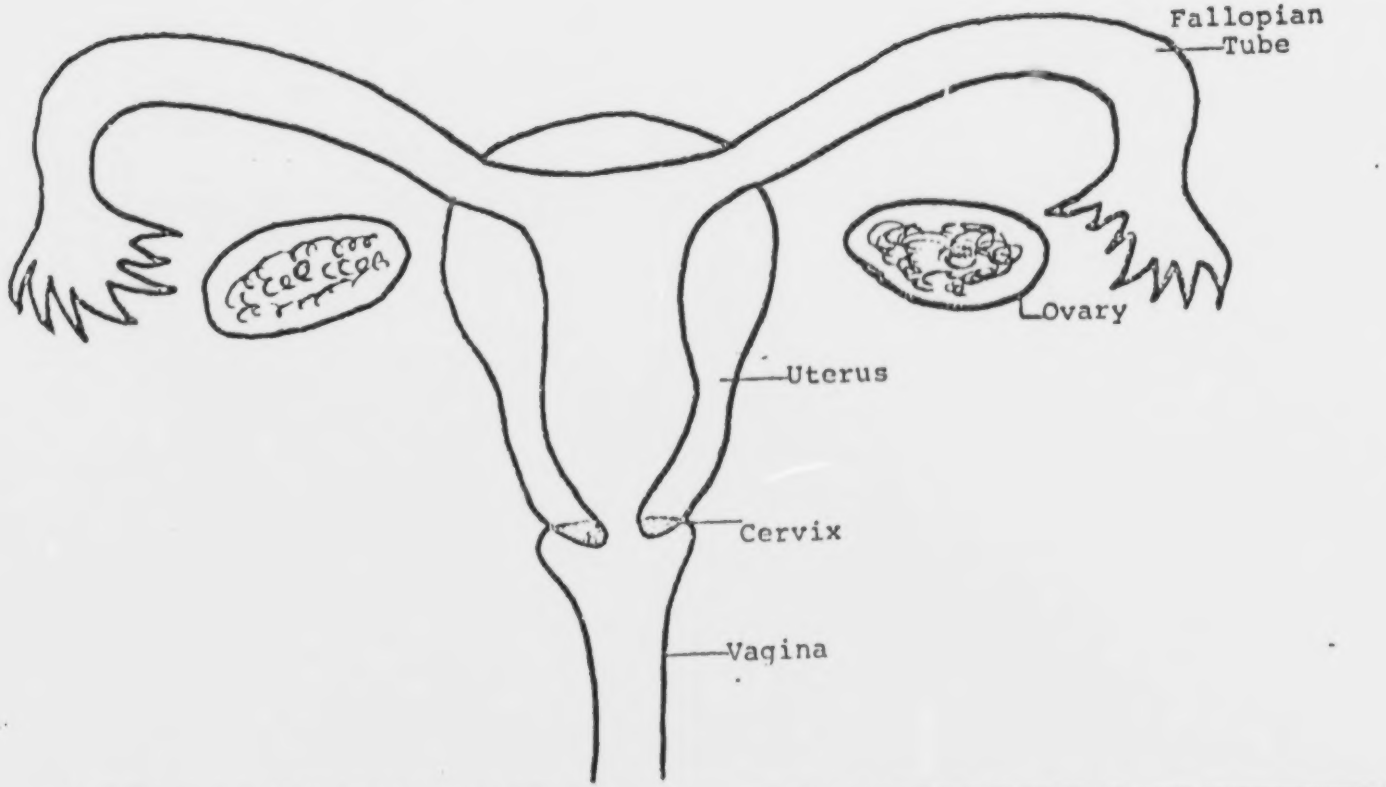
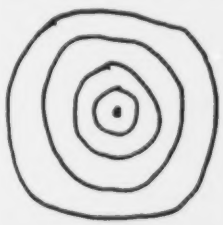


Social Health Association of Cincinnati, 1984.

PRIVACY

This exercise is designed to create an awareness that some things are hard to talk about. It is important, therefore, to recognize one's own limits of self-disclosure. It also allows the student to learn to accept and respect other's feelings about privacy.

1. Ask students to draw the diagram illustrated below:



Each circle represents a circle of people. The inner circle is oneself. The next circle is close friends or intimates. The next is friends. The last circle is acquaintances -- people you don't know too well. The remaining part outside the circle is strangers. The dot in the center is no-one -- not even yourself.

2. Begin the activity by stating that there are certain things people tell only to their close friends, other things that people will tell to anyone. This exercise will help students look at what is most private for them personally.

3. Ask six or seven questions beginning with the phrase "whom would you tell". Have students indicate, either by number or by an underlined key word or phrase, the circle which best represents with whom they would share their response. Emphasize that they will <u>not</u> be sharing their responses with the class; all of their responses will be kept private.

Sample questions:

Whom would you tell . . .

Whom you <u>voted</u> for in the last election?

Whether or not you've ever had <u>sex?</u>

Your method of <u>birth control</u>?

That you thought you had an <u>STD</u>?

Whom you consider most <u>attractive</u>?

That you really <u>like</u> somebody a lot?

The story of your first <u>love</u>?

What <u>career</u> you hope to have?

About <u>family problems</u>?

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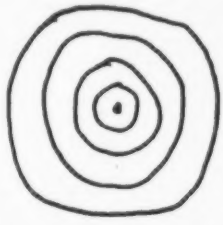

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Your method of birth control?

That you thought you had an STD?

Whom you consider most attractive?

That you really like somebody a lot?

The story of your first love?

What career you hope to have?

About family problems?

4. Then ask the following questions:

   Where did you put most of your responses?

   Was it difficult to decide which circle was most appropriate?

   What conditions or circumstances might have changed your answers?

   Where would you place your parents in the circles?

   Where would you place your other relatives -- grandparents, aunts, uncles and siblings?

   What kinds of issues are most private for you?

   What kinds of issues would you feel comfortable talking about with anyone?

   What kinds of things should it be all right to talk about in a high school sexuality education class?

5. Summarize and explain that it is sometimes difficult to decide which circumstances are appropriate for sharing and which circumstances are not. Furthermore, we tend to put conditions on the sharing of information; i.e., why it is being asked and how it is going to be used.

6. Discuss the importance of respecting privacy, including the privacy of both students and teacher, in this class.

Adapted from Sidney B. Simon et al, Values Clarification: A Handbook of Practical Strategies for Teachers and Students, Hart Publishing Co., 1972.

Our choices about appropriateness of behaviors are very individual decisons. We form expectations based on our own priorities and values. In an attempt to better understand your own decision making, please indicate your approval or disapproval of the following behaviors for your mentally retarded son or daughter.

+ APPROVE
- DISAPPROVE
± NEUTRAL/DON'T CARE

	PRIVATE					PUBLIC					
BEHAVIOR	OWN BEDROOM; DOOR OPEN	OWN BEDROOM: DOOR CLOSED	BATHROOM	KITCHEN	LIVING ROOM	NEIGHBOR-HOOD SIDEWALK	BUS	CENTER AISLE KROGERS	CHURCH	SCHOOL WORK-SHOP	SOCIAL GATHERING: PARTY, PICNIC, BALLGAME, THEATRE
DISROBING											
PLACING HANDS INSIDE OWN CLOTHING TO TOUCH CHEST, BREASTS, ABDOMEN, BUTTOCKS, GENITALS.											
TOUCHING OWN GENITALS FOR PLEASURE (MASTURBATION)											
SHAKING HANDS WITH: PARENTS											
SIBS											
UNCLE											
SAME SEX PEER											
OPPOSITE SEX PEER											
YOUNGER CHILD											
OLDER NEIGHBOR											
TEACHER											
STRANGER											

BEHAVIOR	PRIVATE					PUBLIC					
	OWN BEDROOM; DOOR OPEN	OWN BEDROOM: DOOR CLOSED	BATHROOM	KITCHEN	LIVING ROOM	NEIGHBOR-HOOD SIDEWALK	BUS	CENTER AISLE KROGERS	CHURCH	SCHOOL WORK-SHOP	SOCIAL GATHERING: PARTY, PICNIC, BALLGAME, THEATER
HOLDING HANDS WITH: PARENTS											
SIBS											
UNCLE											
SAME SEX PEER											
OPPOSITE SEX PEER											
YOUNGER CHILD											
OLDER NEIGHBOR											
TEACHER											
STRANGER											
EMBRACING (HUG) PARENTS											
SIBS											
UNCLE											
SAME SEX PEER											
OPPOSITE SEX PEER											
YOUNGER CHILD											
OLDER NEIGHBOR											
TEACHER											

BEHAVIOR	PRIVATE					PUBLIC					
	OWN BEDROOM; DOOR OPEN	OWN BEDROOM: DOOR CLOSED	BATHROOM	KITCHEN	LIVING ROOM	NEIGHBOR-HOOD SIDEWALK	BUS	CENTER AISLE KROGERS	CHURCH	SCHOOL WORK-SHOP	SOCIAL GATHERINGS: PARTY, PICNIC, BALLGAME, THEATRE
STRANGER											
KISSING											
PARENTS											
SIBS											
UNCLE											
SAME SEX PEER											
OPPOSITE SEX PEER											
YOUNGER CHILD											
OLDER NEIGHBOR											
TEACHER											
STRANGER											
PLACING HANDS ON THE CLOTHED CHEST OR BODY OF											
PARENTS											
SIBS											
UNCLE											
SAME SEX PEER											
OPPOSITE SEX PEER											
YOUNGER CHILD											
OLDER NEIGHBOR											

BEHAVIOR	PRIVATE					PUBLIC					
	OWN BEDROOM; DOOR OPEN	OWN BEDROOM: DOOR CLOSED	BATHROOM	KITCHEN	LIVING ROOM	NEIGHBOR-HOOD SIDEWALK	BUS	CENTER AISLE KROGERS	CHURCH	SCHOOL WORK-SHOP	SOCIAL GATHERING: PARTY, PICNIC, BALLGAME, THEATRE
TEACHER											
STRANGER											
PLACING HANDS UNDER CLOTHING TO TOUCH BODY OF PARENTS											
SIBS											
UNCLE											
SAME SEX PEER											
OPPOSITE SEX PEER											
YOUNGER CHILD											
OLDER NEIGHBOR											
TEACHER											
STRANGER											
ALLOWING INTIMATE TOUCHING FROM PARENTS											
SIBS											
UNCLE											
SAME SEX PEER											
OPPOSITE SEX PEER											

	PRIVATE					PUBLIC					
BEHAVIOR	OWN BEDROOM; DOOR OPEN	OWN BEDROOM: DOOR CLOSED	BATHROOM	KITCHEN	LIVING ROOM	NEIGHBOR-HOOD SIDEWALK	BUS	CENTER AISLE KROGERS	CHURCH	SCHOOL WORK-SHOP	SOCIAL GATHERING: PARTY, PICNIC, BALLGAME, THEATER
YOUNGER CHILD											
OLDER NEIGHBOR											
TEACHER											
STRANGER											
MUTUAL TOUCHING FOR PLEASURE (MASTURBATION) WITH PARENTS											
SIBS											
UNCLE											
SAME SEX PEER											
OPPOSITE SEX PEER											
YOUNGER CHILD											
OLDER NEIGHBOR											
TEACHER											
STRANGER											

SEXUAL INTERCOURSE:

IN MARRIAGE WITH CONTRACEPTION ☐

IN MARRAIGE WITHOUT CONTRACEPTION ☐

IN A MEANINGFUL RELATIONSHIP WITH CONTRACEPTION ☐

IN A MEANINGFUL RELATIONSHIP WITHOUT CONTRACEPTION ☐

AT WILL ☐

NOT AT ALL ☐